A STUDY OF THE RELATIONSHIP OF ALCOHOLISM TO FAMILIAL ATTITUDES

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M. E. B.

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INTRODUCTION

Significance of the Study

Alcoholism is a chronic illness, psychic or somatic or psychosomatic, which manifests itself as a disorder of behavior. It is characterized by repeated drinking of alcoholic beverages that exceeds customary dietary use or compliance with the social customs of the community and that interferes with the drinker's health or economic functioning. Some special categories of alcoholics have been identified, including, 'Alcohol Addicts', who cannot control their drinking, and 'Alcoholics with complications'. The latter are those whose excessive drinking has led to recognizable physical or mental sequels.[1]

There is a relatively large number of people in the United States who indulge excessively in the drinking of alcohol. As a result this has become a national problem. "It has been estimated that there are over one and a half million people in the United States who are social problems by reason of the excessive use of alcohol."[2]

> There is no group of persons in greater need of understanding than the alcoholic because of the adverse effect which drinking has on his life. Five out of six alcoholics are men between the ages of 30 and 55 - the most productive years. Alcoholism constitutes a major problem.[3]

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[1] Mark Kellar and Vera Efron, "The Prevalence of Alcoholism", Quarterly Journal of Studies of Alcoholics, XVI(December, 1956), p. 621.

[2] O. Spurgeon English and Gerald Pearson, Emotional Problems of Living (New York, 1955), p. 500.

[3] Arthur P. Noyes, Modern Clinical Psychiatry (Philadelphia, 1956), p. 183.

> The alcoholic's use of liquor - plus its resulting nervous strains and reactions, and his own nervous pressures will interfere directly or indirectly with one or more of his important life activities. His drinking harms himself, his family, or his standing in the community.[1]

The exact relationships of various factors which appear to contribute to alcoholism are not exactly known.

> Extensive clinical findings indicate that the alcoholic's personality structure was strongly molded by early damaging experiences and that his behavior is characterized by the survival of early emotional responses, particularly those involving tolerance for pain or pleasure.
>
> The exact relationships of the various factors which appear to contribute to the development of alcoholism are not precisely known, and require extensive additional study.[2]

Richard S. Cook, M. D., Medical Director, Portal House, Chicago, Illinois, feels that the exact nature of the early disturbance between the problem drinker and the important adults to whom the alcoholic related during infancy and childhood has not been solved.

> I shall merely mention the influence of the early life history upon the subsequent development of clinical alcoholism. The exact nature of the early disturbance between the problem drinker and the important adults to whom he related during infancy and childhood has not been solved, although some careful work has been done on the subject.[3]

This study was concerned with parental attitudes and how these attitudes influenced alcoholism.

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[1] Robert V. Seliger, Alcoholics Are Sick People (Baltimore, 1945), pp. 2-3.

[2] Ernest A. Shepperd, "Alcoholism", Social Work Yearbook (New York, 1954), p. 43.

[3] Richard S. Cook, "Guides to the Therapy of the Alcoholic", American Journal of Orthopsychiatry, XXV(October, 1955) p. 839.

Purpose of the Study

To study the attitudes of parents toward their children and the relation of these attitudes to alcoholism and the prevalence of these attitudes in the parents of 25 alcoholic patients at the VA Hospital, Tuskegee, Alabama.

Method of Procedure

The case study method was used. Patients for this study were chosen from a list of patients whose diagnosis was, primarily or secondarily, alcoholism at the Veterans Administration Hospital, Tuskegee, Alabama.

From a current alphabetical list of these patients, the first case was selected and every tenth case thereafter for the total of twenty-five cases used in this study. The writer used cases that were active during September, 1957 through December, 1957 because all of the data desired could not be obtained from patients' folders; the data was secured by personal interviews and patients' clinical folders. The writer disregarded general, social and cultural factors such as age, race and religion in the selection of patients.

The writer used a schedule in securing data on each of the patients. The schedule included separate attitudes of mother and father toward these areas of parent-child relationships: religion, sex, discipline, eating, recreation, education, and toilet training. The following attitudes were used: over-strictness, over-protectiveness, rejection, and permissiveness. While over-strictness, over-protectiveness

and rejection are considered as negative attitudes, permissiveness is considered as positive. These concepts of attitudes were taken from Levy,[1] Effie Martin Irgens,[2] and Lehner and Kube.[3] These data were supplemented by the writer's attendance at the case staffings. Pertinent literature, published and unpublished, and the writer's personal knowledge of human behavior were used as a frame work of reference for securing findings.

Scope and Limitations

This study included twenty-five cases, which is a small number of alcoholic patients in the world. All of the cases were taken from one hospital, all of the patients were males, and the study was limited to six months.

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1 David M. Levy, Maternal Overprotection (New York, 1943), p. 55.

2 Effie Martin Irgens, "Must Parents' Attitudes Become Modified in Order to Bring About Adjustment in Problem Children?", Smith College Studies in Social Work, VII(September, 1936 - June, 1937), p. 17.

3 George F. J. Lehner and Ella A. Kube, The Dynamics of Personal Adjustment (New York, 1955), pp. 212-214.

CHAPTER II

BACKGROUND OF THE AGENCY

History

In 1921 Congress appropriated over eighteen million dollars for additional facilities for disabled veterans. The President of the United States appointed a committee to make a survey of the needs of the country for such facilities.

The committee's report showed that there were more than three thousand Negroes from the southern states who were World War veterans and made a recommendation to erect a hospital in the south for their care. The committee felt that Tuskegee was a desirable area as the Tuskegee Institute was in that vicinity.

After it was decided that the hospital for Negro veterans would be built in Tuskegee, Dr. Robert Russa Moton, who was then President of Tuskegee Institute, donated four hundred acres of land to be used for that purpose. The United States government accepted his offer.

The United States Veterans' Hospital, No. 91, Tuskegee, Alabama, was initially constructed in the latter part of 1921. It was formally dedicated on February 12, 1923.[1] Doctors Charles M. Griffith, Joseph H. Ward, Eugene Dibble, Jr., and T. T. Tildon served in succession as managers of the hospital. At present the hospital is being managed by Dr. P. P. Barker.

The designation of the station has undergone several changes.

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[1] Eugene H. Dibble, Jr. "A Paper on the Origin, Growth and Development of the Veterans' Hospital", (Tuskegee Veterans Administration Hospital, 1944), p. 7. (Mimeographed).

From 1923 to 1930, it was known as the Veterans Bureau Hospital, No. 91, after which it became known as the Veterans Administration Hospital. In 1933, with the opening of a three hundred and fifty bed domiciliary unit the name was changed to the Veterans' Administration Facility and presently it is referred to as the Veterans' Administration Hospital.[1]

Present Organization

The hospital accommodates over 1900 patients. It is classified roughly as a Neuropsychiatric hospital since approximately seventy percent of the patient load is mentally and emotionally disturbed veterans of at least three wars, World War I, World War II and the Korean Conflict.[2]

The benefits provided by the Veterans Administration are chiefly of three kinds; monetary benefits such as pensions, disability compensations and government insurance; medical treatment and hospitalization, domiciliary care, burial and funeral expenses.[3]

The hospital consists of twenty-eight wards allocated to the treatment categories of medicine, surgery, physical medicine and rehabilitation, neuropsychiatric and neurological conditions. Patients are admitted on the basis of medical and/or psychiatric evaluation of

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[1] Eugene H. Dibble, Jr., op. cit., p. 1.

[2] Essis Morgan, et. al., Social Service Manual, (Tuskegee Veterans Administration Hospital /n. d./ p. 3. (Mimeographed).

[3] Eugene H. Dibble, Jr., op. cit., p. 1.

information submitted on a form 10-P-10. Preference, of course, is given to service-connected and emergent cases.

A patient may be denied admission or placed on the waiting list if he is determined not in emergent need of hospitalization from the information on 10-P-10, or from veteran's verbal explanation of symptoms and clinical examination. The patient's 10-P-10 is classified in either or three categories: 1) Rejected - not legally or not medically feasible; 2) Waiting List - not emergent, to await available bed space; or 3) Accepted.[1]

The hospital's present organizational structure consists of Administrative and Professional Services. The manager and departments of Supply, Finance, Engineering, Personnel, Communication and Records and Registrar constitute the Administrative Services.

The Chaplaincy Service, Dental Service, Dietetic Service, General Medical and Surgical, Nursing, Pharmacy, Physical Medicine and Rehabilitation, Radiology, Laboratory, Special Services, Neuropsychiatric Service, Psychology and Social Services constitute the Professional Services. The hospital is an inter-disciplinary unit in which each department is able to offer the patient a specific type of service in terms of its specialty.

The General Medical and Surgical Services are responsible for treatment of the physical illnesses of patients. It offers dietary instructions and makes use of other services in regard to the needs of the individual patient.

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[1] Essie Morgan, op. cit., p. 1.

Patients are assigned in the different departments of Physical Medicine and Rehabilitation as a part of their treatment, upon the recommendation of the ward physician. The purpose of the service is to better prepare the patient for gradual adjustment during his stay in the hospital and later community living. It offers physical therapy, manual arts therapy, educational therapy, corrective therapy and occupational therapy.

The Acute Intensive Treatment Service, Continued Treatment Service and the Neurology Service constitute the Neuropsychiatric Service. When each psychiatric patient is admitted he is seen by the intake social worker after an examination by the admitting physician. Usually the patient is initially admitted to the Acute Intensive Treatment Service and if the general medical staff feels his condition is chronic and has not improved, he is transferred to the Continued Treatment Service. The Neurological Service deals with those patients who have developed mental disorders as a result of organic mental deterioration and/or chronic and acute brain damage and neurological disorders involving the lower spine, causing no mental reaction.

The Nursing Service is composed of nurses who function on all medical and psychiatric services. They, along with the nursing assistants, provide nursing care and custodial assistance to patients.

Special Services supervises and plans programs for recreation and entertainment of patients. The services include the Patient Library, weekly dances, sports and other entertainment programs such as movies and ward parties.

The chaplains provide the ministry of religion through worship services, bedside visitation and counseling.

The Psychology Service is composed of the clinical and counseling psychologists, who administer mental tests in order to aid in the understanding of the psychic personality of the patient. This service also offers counseling to patients who have problems concerning occupations and vocations for which they are best suited after discharge from the hospital.[1]

The Role of Social Service in the Setting

The Social Service Department was organized on November 2, 1926 at which time it was operated under the Red Cross. The staff consisted of one worker until February, 1944 when an additional worker was hired. The largest number in staff has consisted of twelve workers. Presently there are ten workers. The student training program was begun in 1945. This program, presently in operation, was discontinued in 1948 and was re-instated September of 1956.

In 1936, the Family Care Program was initiated to place on trial visit those neuropsychiatric patients who could not return to their homes because of disturbing elements in the environment, or other reasons.

The Social Work Service Department performs the following major functions, providing services through the practice of social case work in collaboration with physicians and other personnel by:

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[1] Lecture given by members of the hospital staff during student Orientation. (Veterans' Administration Hospital, Tuskegee, Alabama, September, 1957).

1. Identifying (by means of interviews with patients, their relatives and others as well as correspondence) the social, economic and emotional factors involved in the patient's illness affecting his ability and readiness to use medical care to advantage, making available an evaluation of these factors to the physician for his use in the study and treatment of the patient as well as to other services of the hospital when their activities will be facilitated by increased understanding of the patient's circumstances and purposes.

2. Assisting the patient and his family to handle problems in viewpoints, personal relationships, environmental circumstances, financial needs, lacks in resources, and worries over such matters when these tend to retard prompt response to treatment, or cause interruption to it through absence and discharge against medical advice, prolongs hospitalization through aggravation of symptoms or causes relapses and readmissions.

3. Assisting patient in planning immediate and future activities following discharge and the appropriate use of available community social and health agencies with a view toward facilitating prompt discharge upon completion of medical care, conservation of health gains made, and attainment of optimum health and maximum self sufficiency and rehabilitation.

A. Participates in the joint study and planning activities of the Medical Rehabilitation Board, coordinates Social Service activities with Vocational Rehabilitation activities.

B. Provides assistance for the after care of the patients in need of an examination at regular intervals (TBC, etc.) and makes referrals to health agencies for out-patient care for those who are ineligible to receive it from VA.

C. Coordinates hospital and Regional Office Social Service activities in providing for assistance to patients.

D. Responsible for orientation of workers, staff development programs, social work students; participates in educational programs for residents, personnel and volunteers to develop their understanding of the social aspects of illness.

E. Participates in social research in the health field and collaborates with physicians in the social aspects of medical research.

F. Participates with community agencies in recognizing

> and planning means for meeting unmet needs in community social and health services essential to veterans in supplementing health gains through VA resources.[1]

The social worker is a liaison between the patient, hospital and his family. She works with medical team to help them understand the patient's social situation in regard to the emotional components of his illness and his total acceptance of treatment which will enable the patient to receive the maximum in medical treatment.

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[1] Essie Morgan, et. al., Social Service Manual (Tuskegee Veterans Administration Hospital) [n. d.] pp. 5-6.

CHAPTER III

A STUDY OF PARENTAL ATTITUDES AND THEIR RELATIONSHIP TO ALCOHOLISM

Theoretical Framework

The child's dependence on his parents is not limited to the fulfillment of his physical needs such as food and shelter. The developing child is unquestionably exposed to many situations which are accompanied by fear or guilt, and his defenses against these strong and inevitable fears are not necessarily illogical ones. It may be a defense that takes the form of uncritical identification with strong, loving and affectionate parents whose high regard of him is uncritically internalized and transformed through identification into an enduring high self regard, self-esteem, and a self-confident approcah to subsequent and later problems.[1]

In this study, the writer was interested in discovering how parental attitudes of over-strictness, over-protectiveness, permissiveness and acceptance, and rejection caused or influenced certain personality difficulties which are significant in the inadequate functioning of the alcoholics. The writer chose to study these areas of parent-child relationships: religion, sex, discipline, toilet training, eating, recreation, and education.

Lehner and Kube define authoritarianism and over-strictness as enforced excessive discipline. Parents demand strict obedience

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[1] Fritz Kant, The Treatment of the Alcoholic (Springfield, Illinois, 1954), pp. 24-25.

And are quick to punish any deviation from prescribed behavior. Many times parents set standards for the child which they cannot possibly meet. The sternly disciplined child will become highly dependent on his parents, since all decisions are made for him, or he may also grow defiant and aggressive.[1]

Thorpe and Cruze agree with Lehner and Kube's definition of authoritarianism and over-strictness and further stated that such restrictions, as a rule, produce one of the two reactions - either the child will continue to submit to authority, discontinue his attempts to grow up, and remain completely dependent upon older persons, or he will rebel openly.[2]

Shaffer and Shoben also agree with Thorpe and Cruze and Lehner and Kube, but added that if the child tries aggressive defenses, he is suppressed and if he tries to withdraw, his parents force him into activity. Thwarted at every turn, he develops no adjustive resources of his own and must simply remain unadjusted.[3]

Levy states that over-protection is synonymous with excessive care of children. Its manifestations in the mother-child relationship have been grouped, according to the manner in which they occur, under four headings. Three of these concern activity primarily and paraphrase the common observations: 1) "the parent is always there";

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[1] George F. J. Lehner, and Ella A. Kube, The Dynamics of Personal Adjustment (New York, 1955), p. 214.

[2] Louis P. Thorpe and Wendell W. Cruze, Developmental Psychology (New York, 1956), p. 30.

[3] Laurance Frederic Shaffer and Edward Joseph Shoben, Jr., The Psychology of Adjustment (Boston, 1956), p. 441.

2) "the parent still treats him like a baby"; and 3) "the parent never allowed him to grow up" or "the parent won't take the risks". The expressions are rendered into groupings: 1) excessive contact; 2) infantilization; and 3) prevention of independent behavior. Consequently the child becomes overly dependent and fails in situations that require initiativeness and independence.[1] Martin and Stendler,[2] Lehner and Kube,[3] and Lippman[4] agree with Levy's interpretation of over-protection as well as its effect upon the child.

Shaffer and Shoben also agree with Levy's interpretation of over-protection and its effect upon the child. In addition, over-protection or possessiveness accounts for the child's anxiety whereas the type of parental control determines which mechanism-demanding dependency or abject submission - the child uses to deal with other people and to control his own fears.[5]

Lehner and Kube stated that a permissive atmosphere can be described as one in which the child can develop his potentialities and learn the necessary motor and social skills without undue pressure. A permissive atmosphere also means that the demands made on the child should be

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[1] Op. cit., p. 37.

[2] William E. Martin and Celia Burns Stendler, Child Development (New York, 1953), p. 392.

[3] Op. cit., p. 213.

[4] Hyman S. Lippman, Treatment of the Child in Emotional Conflict (New York, 1956), p. 145.

[5] Op. cit., p. 441.

kept in line with his abilities and his level of development, so that he will not become discouraged by failing to achieve what is beyond his capacities. If a child is to achieve emotional security it is essential that he be accepted as he is, consequently the home atmosphere should be permissive.[1] Martin and Stendler[2] also agree with these authors.

Lehner and Kube describe the rejecting parents as those who abandon the child, who isolate or seclude him, lock him up in a room or punish him at the slightest provocation or deny him things that he wants. A rejected child will become hostile and rebellious. Evidence also indicates that rejection may result in physiological, mental and social retardation.[3] Rejecting parents are very curt when conversing with the child or tell the child to be quiet.[4] Martin and Stendler add that the child might become submissive and nervous.[5]

Lehner and Kube consider the following attitudes as negative: Over-protection, over-strictness and rejection. This one is considered as positive: permissiveness.[6]

English and Pearson stated that every person with an alcoholic problem has a personality difficulty. Every alcoholic is an

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[1] Op. cit., p. 215.

[2] Op. cit., p. 215.

[3] Op. cit., pp. 212-213.

[4] O. Spurgeon English and Gerald Pearson, Emotional Problems of Living (New York, 1955), p. 115.

[5] Op. cit., p. 215.

[6] Op. cit., pp. 211-216.

immature, insecure, over-sensitive and anxious person suffering from marked feelings of inferiority.[1] Lolli stated that alcoholics have inferiority-superiority conflicts, extreme dependency needs, demandingness and manipulation, confusion regarding sexuality, guilt, self-rejection, self-destructive tendencies, and low frustration tolerance.[2]

Religion

The religious attitudes of the parents have a definite effect upon the child's acceptance or rejection of any refuge which the institution of religion promises. Whal also found this to be true in his studies of alcoholics.

> It seems probable from clinical experience, that the nature and degree of the prior relationship with the primary figures in childhood are more important in the genesis of self-concepts than in any specific religious training. If the concept of deity is formed as many think, from a conscious and unconscious distillation of attitudes held toward the parents then it is not unreasonable to infer that prior traumatic experiences with capricious, punitive or rejecting parents would enter into the religious life and strongly color the individual's conception of the nature of divinity.[3]

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1 Op. cit., p. 500.

2 Giorgio Lolli, "The Addictive Drinker", Quarterly Journal of Studies of Alcoholics, X (June, 1949), pp. 404-414.

3 C. W. Whal, "Some Antecedent Factors in the Family Histories of 109 Alcoholics", Quarterly Journal of Studies of Alcoholics, XVI (December, 1956), p. 647.

The parents' interpretation of religion has an effect upon the child's conception of religion. However, many times no interpretation is given. Groves found this to be true in previous studies. "The child's poverty of insight makes him an easy victim of imagination and when his parents suffer by faulty interpretations or no interpretations, their reactions are multiplied by his own."[1]

There were 25 patients whose mothers exhibited over-strictness, in the area of religion. Nine of the patients' fathers exhibited over-strictness, 13 permissiveness, and 3 rejection. This case excerpt serves to illustrate familial attitudes in this area.

Case No. 1

> Mr. C was very talkative and eager to ventilate his hostile feelings toward his parents. While referring to religion he related that his mother demanded that he attend church regularly. His father seldom went to church or expressed any concern about religion. His mother accompanied him almost every Sunday.
>
> He was never allowed to express his feelings if he did not want to go, and if he attempted to do so he was reprimanded. He had little interpretation of religion and he felt everything, with reference to religion, was a "don't". He was taught that card games, betting, drinking alcoholic beverages, "talking back" to his parents, and playing any form of games on Sunday were all sinful. He thinks these things are all right, that is why he does them, but he also feels guilty when he indulges, therefore he feels he could never make an adjustment at home if he were to return. He does not "see" the necessity of attending church but if he does not attend he feels guilty.

In the area of religion, Mr. C's personality difficulty is exhibited by his marked feelings of guilt when he attempts to deny

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[1] Ernest R. Groves, The Family and Its Social Function (New York, 1940), p. 283.

his dependency, which resulted from his mother's over-strictness. She did not allow him the opportunity of expressing himself or making decisions, but forced her attitudes on him. Mr. C was defiant of his mother's attitude toward religion but was unable to accept his own attitude without feelings of guilt because of forced dependency by his mother. This supports Lehner and Kube's concept that "the sternly disciplined child will become highly dependent on his parents, since all decisions are made for him, and he may also grow defiant".[1] Mr. C's continuance to submit to authority, because he feared being reprimanded, further supports Thorpe and Cruze's concepts of reactions, discussed earlier in this chapter.

Extreme dependency needs and guilt characterized Mr. C's symptomatic behavior which is characteristic of alcoholics. Mr. C's dependency needs and guilt were influenced by the parental attitude of over-strictness in the ares of religion.

Sex

Hurlock found in her compilation of studies, with reference to sex, that most parents rarely gave their children sex instructions.

> How much information concerning sex is given by parents has been the subject of a number of investigations. Reports to questionnaires show that a startling large percentage of parents make no attempt to give instruction in this field to their children.[2]

There were 25 patients who related that their mothers exhibited

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1 Op. cit., p. 214.

2 Elizabeth B. Hurlock, Adolescent Development (New York, 1949), p. 442.

over-strictness in the area of sex, They related that 21 fathers were over-strict and 4 were permissive in this area. This attitude of over-strictness on the part of the parents, was still effective in the adulthood of the patients as they were reluctant and somewhat shy about discussing sex with the writer. This case excerpt serves to illustrate familial attitudes in this area.

Case No. 2

> Mr. K stated that he never heard his parents express their desire as to whether they wanted a girl or boy at his birth. Sex was a hush-hush subject in his home. They refused to discuss sex with him or in his presence. Once he remembered asking his mother about the birth of babies and she told him that they were found in stumps in the woods. When he attempted to question her further, she told him to "shut up" and that he should not talk about such things. This made him curious and the more he thought about it, the more confused he became.
>
> He lived on a farm and had the experience of seeing the birth of a calf. He attempted to explain it to his sisters and brother in the presence of his parents. His father scolded him and told him that he was being "bad", and forbade him to ever talk that way again. He felt somewhat ashamed and guilty of being bad. He never approached his parents again with any subject concerning sex.
>
> At school he had the experience of discussing sex with his friends and he learned much erroneous material. Much of this he could not understand and it also gave him the feeling that sex really was "nasty". He learned the true facts of sex after he approached adulthood, but he does not feel secure discussing it with others; however, he knows and understands that it is a normal process of life.

Mr. K's experience of over-strict parental attitudes in the area of sex contributed toward his feelings of insecurity in this area, as he was given the impression that it was something to be ashamed of. Hurlock feels that the secrecy of sex leaves an impression. "Furthermore because the impression is apt to grow up that sex is

Something to be ashamed of."[1]

Mr. K's feelings of insecurity characterizes some symptomatic behavior exhibited by alcoholics.

Discipline

If parental authority is too rigid, typical symptoms make their appearance which, if unalleviated, often leads to permanent maladjustments. Bakwin feels that parental attitudes toward discipline are just as important as the method of discipline used. "Authority which is firm, kind, reasonable and consistent gives the child that sense of security which is essential for emotional development."[2]

Anderson feels that if discipline is too strict it is most times ineffective toward helping the child to achieve the desired goals.

> To use authority or to command obedience is a simple way of telling the child that one does not have confidence in him, that one distrusts either his judgment or his good intentions. There is not a child who is insensitive to distrust and disrespect. He cringes under it or he fights against it.[3]

Bakwin feels that bribing is of no value and should not be resorted to, since the child will repeat the same behavior, thereby impeding mature behavior. "Training and discipline are implements to direct the child's energies into useful and socially acceptable channels, to assist him in outgrowing less mature modes of behavior,

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1 Ibid., p. 443.

2 Harry Bakwin, Behavior Disorders in Children (Philadelphia, 1953), p. 65.

3 Harry H. Anderson, The Children in the Family (New York, 1937), p. 61.

to curb emotional demands."[1]

These patients related that 17 of their fathers and 10 mothers were over-strict in the area of discipline while 8 fathers and 11 mothers exhibited permissiveness. Four mothers exhibited over-protectiveness in this area. This case excerpt illustrates familial attitudes in the area of discipline.

Case No. 3

Mr. H. stated that his mother disciplined him, but not rigidly. She mostly resorted to talking and allowed him much freedom. Many times when he misbehaved she would let him off with a warning. She never made excuses for him and would openly point out his faults. Even though she "gave in" to him, he feels that she punished him sometimes when it was unnecessary. His mother sometimes punished him when he forgot to do a chore. He feels that children are human and liable to forget, and he feels that these punishments were unnecessary. He feels that stealing, lying, cheating and disobeying a parental demand that might cause bodily harm are things that children should be punished for. These things she sometimes punished him for and many times she did not.

He feels that his mother did not consider his feelings when he was approaching punishment but she punished him according to her physical feelings at that particular time. During the times when she resorted to talking to him, when he misbehaved, she forbade him to express himself. If he attempted to do so, he was sure to be punished for being "impudent".

Occasionally his mother offered him rewards for good behavior. He feels that this did not help too much as he was only being good to receive the reward and not because he felt or understood the necessity of doing so.

Mr. H related that his father was an overly-strict disciplinarian. When his father told him to do something, he had to do it or receive corporal punishment. He would try to do as his father demanded because he feared punishment. His father never considered his feelings, neglected disciplining or offered rewards for good behavior.

Mr. H said that he is still reluctant to speak out when he disagrees with someone of authority unless he has had a "nip" to give him a "lift".

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[1] Op. cit., p. 65.

Mr. H's father was considered as being over-strict in the area of discipline because he demanded strict obedience and was quick to punish when a deviation of behavior occurred. Mr. H seemingly submitted to authority because of his conditioning by the parental attitude of over-strictness in this area, because he was not allowed the freedom of expressing himself without a painful experience occuring later. Immaturity was exhibited by Mr. H in that he was unable to exercise his feelings and convictions unless he was drinking.

Mr. H's immaturity, which was seemingly conditioned by the parental attitude of over-strictness in the area of discipline is characteristic of symptomatic behavior exhibited by alcoholics.

Eating

Hurlock feels that the parents' training and attitudes about the child's eating is as important as the specific technique used to try to get him to eat. "When problems arise with children, the trouble can often be traced to wrong training and unwholesome attitudes on the part of the adults who are responsible for them."[1]

In this study the patients revealed that 16 of their fathers and 12 mothers exhibited over-strictness in the area of eating while 13 of their mothers and 9 fathers exhibited permissiveness. This case excerpt serves to illustrate familial attitudes in the area of eating.

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[1] Op. cit., p. 171.

Case No. 4

Mr. V related that his father usually fixed his plate and he had to eat everything on it. He did not have a choice of the selection of food on the table that he wanted to eat. He had to adhere to strict table manners. He was not allowed to talk at the table as his father would tell him to "let his vittles hush his mouth". He related that if he did not adhere to strict table manners, he would have to leave the table without finishing his food and sometimes would have to go to bed.

He related that most of the time he felt very bored during meal times. Many times he left the table over-stuffed or hungry. He seldom asked for more food for he feared the punishment he might possibly receive from his father if he would be unable to eat it all.

He ate three meals per day and was allowed to eat bread between meals. He feels his father could have provided them with more of a variety of foods. He lived on a farm and ate foods according to what was growing during that season. Many times he would be so tired of the same food that he had to force it down.

His mother never scolded him about food and when his father was away, he felt relieved because he knew his mother was lenient.

Mr. V's experience of over-strict parental attitudes in the area of eating is characterized by his father's enforced demand of strict obedience (adhering to strict table manners) and his quickness to punish when a deviation of prescribed behavior occurred. Mr. V submitted to his father's demands because he feared punishment. This submission may possibly have contributed to dependency, which is a characteristic of symptomatic behavior exhibited by alcoholics.

Recreation

Levy feels that it is important that children play with other children for normal growth. "The modification of egocentric behavior is part of normal growth. It functions best when children

have opportunities to play with others without undue supervision."[1]

In this study the patients' revealed that 15 mothers exhibited over-protectiveness and 10 permissiveness in the area of recreation. There were 17 whose fathers exhibited strong rejection and 8 permissiveness. This case excerpt illustrates familial attitudes in the area of recreation.

Case No. 5

Mr. S spoke emphatically as he related that, "I had to work hard ever since I can remember myself. My father believed in working first and playing later." He lived on a farm and his father delegated chores for him to perform, which kept him very busy. On Saturdays he usually had his work finished by noon and he used the afternoon for recreation.

His father would complain to him that he never had time to supervise or engage in any form of recreation with him, however, he feels that his father had the time but did not recognize the necessity of recreation because of his own childhood experiences. His father never seemed to have been annoyed by play activities around the home, so long as his chores and school work were finished and he was off to bed by nine o'clock.

He feels that his mother spent all the possible time, that she could afford, engaging in some form of recreation with him. He related that his mother would parch peanuts or make candy for them and join them in playing games on week-ends.

His mother supervised his play activities closely. Most of the time she had to know everything possible about any form of activity that he was to engage in outside of the home. She was very critical and if it did not meet her approval, she would not allow him to go. Sometimes when it met her approval, she would not allow him to go and would make excuses such as, "that old bad crowd will be there", or "something might happen to you". He feels that his mother wanted him to enjoy himself, but could not bear having him to leave home from under her watchful and protective eyes, because many times she would accompany him to school socials and would keep him close to her.

Mr. S feels that he left home at an early age (17 years old) because his mother did not want him to seek

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[1] Op. cit., p. 173.

> recreational activities outside of the home and because of his father's inability to recognize the necessity of promoting and engaging in recreational activities with him. He related that he was anxious to get out with other boys and enjoy some of the fun that they would tell him about.
>
> Sometimes he feels ashamed and guilty for having "taken up with" some of the crowds he ran around with, because he knew his mother and father would not have approved of some of the things that they did, such as gambling and drinking. When he sits down to think about it, he feels that he made a big mistake, however, he feels that this is part of life. He feels, because drinking and gambling caused him to neglect his financial obligations, that it will be an advantage to him to find some other worthwhile recreational activities.

Mr. S's experiences of over-protectiveness by his mother in the area of recreation is characterized by his mother's prevention of independent behavior in that she never allowed him to take the risk of becoming involved in "bad crowds" and in her treating him like a baby because she feared "something would happen to him". Mr. S resorted to dependency, which can be expressed as abject submission, and later defiant behavior which he expressed immaturely. Because of his way of expressing his defiant behavior he has guilt feelings.

Mr. S's dependency, immaturity and feelings of guilt are characteristics of symptomatic behavior of alcoholics.

Mr. S's experience of over-protection by his mother fostered his serious problem in adjustment. Lippman stated that "the child who has been over-protected and indulged presents a serious problem in adjustment."[1]

Education

Cuber feels that the status of a child is affected by his

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[1] Op. cit., p. 145.

family. "Family conditioning may cause a child to be socially rejected, or accepted in a way which would imply lower status than he would like."[1]

In this study the patients related that 3 of their mothers exhibited over-strictness, 1 over-protectiveness, 6 rejection, and 15 permissiveness in the area of education. There were 7 fathers who exhibited over-strictness, 8 rejection and 10 permissiveness in the area of education.

This case excerpt serves to illustrate familial attitudes of over-strictness exhibited by 8 of the patients' fathers in the area of education, and permissiveness exhibited by 15 patients' mothers.

Case No. 6

> Mr. L stated that his father "put his foot down" and demanded that he attend school regularly. He never allowed him to express his feelings as to how he felt about school and if he attempted to do so he was scold. His father demanded that he attend school as he felt it was for his own benefit. His father never attempted to push him beyond his ability because he was always pleased with his grades, which were usually Bs and As.
>
> He said there were times when he felt ashamed and discouraged because he did not have clothes or supplies as others had. When he would ask his father for clothes he would tell him that his clothes were good enough for school. This made him angry for he knew his father could have given him better clothes.
>
> Mr. L related that his father would tell others how well he was doing in school and this made him want to excel because he did not want to "let him down". His father never attempted to select a career for him, but wanted him to have an education so he could possibly have an adequate income.
>
> Mr. L related that his mother required him to attend school regularly, but not in a demanding way, as she was anxious to see him succeed. She encouraged him to complete grammar school, high school, college, and graduate school by pointing

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[1] John F. Cuber, Sociology (New York, 1951), p. 505.

out the many advantages of each. She never attempted to push him beyond his ability or choose a career for him. She was accepting of his own rate of progress. She revealed confidence in him and constantly praised him for his efforts.

He has a masters degree in education. He feels that he chose a good field, but because of his illness (alcoholism) he has lost three good jobs. He feels that he is "letting his parents down" because they wanted him to be able to secure a good job.

Mr. L's experience of over-strictness exhibited by his father in the area of education is characterized by his father demanding that he attend school without recognition of Mr. L's feelings. He has feelings of guilt and inferiority because of the loss of three good jobs in that he is not succeeding according to his father's desires.

Mr. L's anxiousness, feelings of inferiority, and guilt are characteristics of symptomatic behavior exhibited by alcoholics.

This case excerpt serves to illustrate familial attitudes of rejection exhibited by 8 of the fathers in the area of education.

Case No. 7

Mr. B stated his father was not too concerned about educating him. He never forced him to attend school and often withheld him from school to perform chores, which made it impossible for him to complete grammar school. His father never encouraged him to complete any of his school requirements. The most important thing to his father was harvesting a good crop. His father never revealed any confidence in him or praised him for his school work. His father never attempted to select a career for him, however his father taught him many things about the farm for his own benefit as his only concern was clothing and feeding him.

Many days, when he had nothing on the farm to do, he did not want to go to school because he felt ashamed of being so far behind in his subjects, but his mother would encourage him to go. His mother was in accord with his father when he was withheld from school to perform farm chores, or she was afraid to speak out against him. His mother realized how much he wanted to complete his training but she knew it was almost impossible because he was withheld from school so often.

She encouraged him to learn as much as he could the days he went. She never attempted to push him beyond his ability and was accepting of his own rate of progress. She revealed confidence in him and constantly praised him for his good marks. She never attempted to select a career for him.

Mr. B pities himself for not having an education and blames his father. He stated that he feels that his father should have allowed him to attend school regularly. He feels that his low economic status is due to his not having an education. He chose farming as a career because he didn't have enough education to do anything else and that was all he knew to do well. He detests farming because he can never make enough to "get ahead".

Mr. B's experience of rejection exhibited by his father in the area of education is characterized by his father denying him the education that he wanted. Because of his father's attitude in this area, Mr. B felt insecure economically and inferior.

Mr. B's feeling of inferiority and insecurity are characteristics of symptomatic behavior exhibited by alcoholics.

Toilet Training

Demands of cleanliness upon the child to control his excretion under unfavorable conditions can lead to a great deal of anxiety and hostility. English and Person feel that the parents' attitude should be one of friendliness and understanding. "A dirty child is considered a wicked and bad child, so a feeling of guilt develops in such surroundings."[1]

These patients related that 25 mothers and 25 fathers revealed permissiveness in the area of toilet training. This case excerpt serves to illustrate familial attitudes in this area.

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[1] Op. cit., p. 44.

Case No. 8

Mr. K related that he was uncertain about the exact age that he was toilet trained, however he was sure that he was toilet trained by the age of three. He seldom had an accident and soiled his clothes, but when he did he was never punished. He was never bribed into the use of the toilet or cleanliness.

He feels that both parents were accepting of his own rate of progress. As he was talking he looked down at his clothes, which were neat, clean and attractive, and related that he was never happy if his clothes were soiled because he always took pride in his personal appearance.

Mr. K's parents exhibited permissiveness in the area of toilet training because they accepted his own rate of progress. Where positive attitudes were shown, there was no symtomatic behavior exhibited that was related to symtomatic behavior of alcoholics.

The primary patterning of personality within the family conditions responses to life situations, thus from all the patterns established from infancy and childhood are determined the following:

(1) Attitudes toward men and women, supervisors and subordinates.

(2) Identification of self with ideals, emotionally motivated attitudes and beliefs which lead to the development of techniques for the achievement of success or failure.

(3) Ethical and moral attitudes.[1]

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[1] Genevieve Alston Hill, "Social Concepts of Course" (Lecture delivered to class in Social Work 505, Atlanta University, Atlanta, Georgia, March 7, 1958.

CHAPTER IV

SUMMARY AND CONCLUSIONS

This study was made at the Veterans Administration Hospital in Tuskegee, Alabama in an attempt to discover how familial attitudes contribute to personality difficulties found in alcoholics and the prevalence of these attitudes in parents of alcoholics.

This study was initiated because of the one and a half million people in the United States who are social problems because of the excessive use of alcohol. Five out of six alcoholics are men between the ages of 30 and 55 - the most productive years. There was a need of further understanding of alcoholics because of the adverse effect that drinking had on their lives, since alcoholism constitutes a major problem. There was also a need for further study of alcoholics because the exact relationships of various factors which apparently contribute to the development of alcoholism are not precisely known and required additional study. It was the hope of the writer that this study would add small knowledge toward meeting this need.

The sample for this study consisted of twenty-five patients who were hospitalized during the period of September 1957 and February 1958. The writer used active cases because all the data desired could not be obtained from patients' folders; the data was secured by personal interviews and clinical folders. Excessive use of alcohol was one of the immediate precipitating factors which caused their admission or readmission to the hospital. General social and cultural factors such as age, race, and religion were disregarded in

the selection of patients.

A schedule was used in securing data on each of the patients. The schedule included separate attitudes of mother and father toward these areas of parent-child relationships: religion, sex, discipline, toilet training, eating, recreation and education. The following attitudes were used: over-strictness, over-protectiveness, permissiveness, rejection and acceptance. These attitudes were defined by literature of Levy, Effie Martin Irgens, and Lehner and Kube.

Lehner and Kube defined over-strictness as enforced excessive discipline. Parents demand strict obedience, are quick to punish when deviation from prescribed behavior occurs, and set standards for the child which he cannot possibly meet. The child's reactions to over-strictness are dependency (since all decisions are made for him), defiant behavior, and aggressiveness. Thorpe and Cruze stated and additional reaction - the child will continue to submit to authority. An additional reaction, stated by Shaffer and Shoben, is that the child develops no adjustive resources of his own.

Levy stated that over-protection is synonymous with excessive care of children, which can be rendered in to three groupings: 1) excessive contact; 2) infantilization; and 3) prevention of independent behavior. The child's reactions are dependency and failure in situations that require initiativeness and independence. Martin and Stendler, Lehner and Kube, and Lippman agreed with Levy's interpretation of over-protection and its effect upon the child.

Lehner and Kube defined a permissive atmosphere as one in which the child can develop his potentialities, learn the necessary motor

and social skills without undue pressure, and one in which the demands made on the child are kept in line with his abilities and his level of development. A permissive atmosphere and acceptance enable a child to achieve emotional security. Martin and Stendler are in agreement.

Lehner and Kube described the rejecting parents as those who abandon the child, isolate or seclude him, lock him up in a room, punish at the slightest provocation or deny him things that he wants. A rejected child will become hostile, and rebellious. Rejection may result in physiological, mental and social retardation. English and Pearson stated that rejecting parents are very curt when conversing with the child. Martin and Stendler further stated that the child might become submissive and nervous.

English and Pearson stated that every person with an alcoholic problem has one of the following personality difficulties: immaturity, insecurity, over-sensitiveness, anxiousness and marked feelings of inferiority. Lolli stated that alcoholics have inferiority-superiority conflicts, extreme dependency needs, demandingness and manipulation, confusion regarding sexuality, guilt, self-rejection, self-destruction tendencies, and low frustration tolerance.

For the purpose of this study these attitudes are considered as negative: Over-strictness, over-protectiveness, and rejection. Permissiveness was considered as positive.

In this study it was found that the patients' mothers' attitudes of over-strictness were distributed as such: 25 religion, 25 sex, 10 discipline, 12 eating and 3 education (see Table I in Appendix).

Attitudes of over-protectiveness were distributed as: 4 discipline, 15 recreation and 1 education. Attitudes of rejection were distributed as: 6 education. The attitudes of permissiveness: 11 discipline, 13 eating, 10 recreation, 15 education and 25 toilet training.

There was a total of 175 manifestations of attitudes, which consisted of 101 displays of negative attitudes and 74 displays of positive attitudes exhibited by these patients' mothers.

In this study it was found that the patients' fathers' attitudes of over-strictness were distributed as: 9 religion, 21 sex, 17 discipline, 16 eating, 2 recreation, and 7 education. Rejection: 3 religion, 17 recreation, and 8 education. Permissiveness: 13 religion, 4 sex, 8 discipline, 9 eating, 6 recreation, 10 education, and 25 toilet training (see Table II in Appendix).

There were 100 displays of negative attitudes and 75 displays of positive attitudes, which constituted a total of 175 manifestations of attitudes.

This study revealed 201 negative familial attitudes and 149 positive attitudes. The writer isolated some symptomatic behavior of these alcoholics, which was influenced by negative familial attitudes, from studying excerpts of eight of the cases used. Extreme dependency needs, guilt, feelings of insecurity, immaturity, anxiousness, and feelings of inferiority characterize the symptomatic behavior of these patients that was influenced by negative familial attitudes. This symptomatic behavior is characteristic of alcoholics, which tended to prove that a definite relationship exists between

negative familial attitudes and alcoholism. There was no relationship found between positive familial attitudes and alcoholism.

The conclusion drawn is that parental attitudes foster or contribute toward symptomatic behavior which is characteristic of personality difficulties of alcoholics. This study further revealed that alcoholism is influenced by negative familial attitudes.

It would seem logical that an initial concern would be in the prevention of alcoholism through social work services to families whose attitudes seem to be of such that they might influence certain symptomatic behavior, in children, that is characteristic of personality difficulties found in alcoholics.

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APPENDIX

TABLE I

ATTITUDES OF MOTHER TOWARD AREAS OF PARENT-CHILD RELATIONSHIPS

Areas of Parent-Child Relationships	Attitudes				
	Negative			Positive	
	Over-Strictness	Over-Protectiveness	Rejection	Permissiveness	Total
Religion . . .	25	-	-	-	25
Sex	25	-	-	-	25
Discipline . .	10	4	-	11	25
Eating . . .	12	-	-	13	25
Recreation . .	-	15	-	10	25
Education	3	1	6	-	25
Toilet Training	-	-	-	25	25
Total . . .	75	20	6	74	175

TABLE II

ATTITUDES OF FATHER TOWARD AREAS OF PARENT-CHILD RELATIONSHIPS

Areas of Parent-Child Relationships	Attitudes				
	Negative			Positive	
	Over-Strictness	Over-Protectiveness	Rejection	Permissiveness	Total
Religion . . .	9	-	3	13	25
Sex	21	-	-	4	25
Discipline . .	17	-	-	8	25
Eating	16	-	-	9	25
Recreation . .	2	-	17	6	25
Education . .	7	-	8	10	25
Toilet Training	-	-	-	25	25
Total	72	-	28	75	175

SCHEDULE

	MOTHER			FATHER		
RELIGION	Yes	No	Uncertain	Yes	No	Uncertain
1. Parent demanded that child attend church regularly.						
2. Parent Attended Church with child regularly.						
3. Parent allowed the child to attend a church of his choice.						
SEX						
1. Parent wanted a girl.						
2. Parent wanted a boy.						
3. Parent preferred not having a child.						
4. Parent refused to discuss sex in presence of the child						
5. Parent refused to discuss sex with the child.						
6. Parent provided sex education for child.						
DISCIPLINE						
1. Parent "gave in" to child.						
2. Parent made excuses for child.						
3. Parent saw few if any fault in child.						
4. Parent punished child severely.						
5. Parent nagged child.						
6. Parent seldom used corporal punishment.						
7. Parent threatened to evict child.						

	Mother			Father		
	Yes	No	Uncertain	Yes	No	Uncertain
8. Parent deliberately frightened child.						
9. Parent never punished child.						
10. Parent punished child only when necessary.						
11. Parent considered child's feelings.						
12. Parent supervised child closely.						
13. Parent revealed confidence in child.						
14. Parent easily annoyed by child's activities.						
15. Parent neglected disciplining child.						
16. Parent offered rewards for good behavior						

TOILET TRAINING

1. Toilet training began prior to ½ years old.
2. Toilet training completed by 3 years old.
3. Toilet training completed by 4 years or longer.
4. Child punished severely when accident occurred.
5. Child bribed into use of toilet.
6. Parent accepted child's own rate of progress.
7. Child derived pleasure from soiling himself.
8. Child took pride in his personal appearance.

	MOTHER			FATHER		
	Yes	No	Uncertain	Yes	No	Uncertain

EDUCATION

1. Child was forced to attend school regularly.
2. Child received formalized training in the home.
3. Child withheld from school.
4. Child was encouraged to complete grammar school.
5. Child was encouraged to complete high school.
6. Child was encouraged to complete college.
7. Child was encouraged to go on to graduate level.
8. Parent left child on his own.
9. Parent attempted to push child beyond his ability.
10. Parent exhibited acceptance of child's own rate of progress.
11. Parent revealed confidence in child.
12. Parent constantly praised child.
13. Parent attempted to select child's career.

RECREATION

1. Parent spent all possible time with child.
2. Parent provided child with excessive money and toys.

	MOTHER			FATHER		
	Yes	No	Uncertain	Yes	No	Uncertain
3. Parent provided child with special rewards.						
4. Parent did not want child to leave home for recreational activities.						
5. Parent neglected child completely.						
6. Parent was easily annoyed by play activities.						
7. Parent supervised child's recreation closely.						

EATING

1. Child was breast fed.						
2. Child was bottle fed.						
3. Child was forced to eat what parent put on his plate.						
4. Child was fed only foods he wished to eat.						
5. Child was required to adhere to strict table manners.						
6. Child was left alone to eat as he wished.						
7. Child was fed regularly.						
8. Child was fed when convenient for parent.						